TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #07-647

DIGEST

Amends 405 IAC 1-12-6 and 405 IAC 1-12-24 to revise the Medicaid reimbursement methodology for nonstate owned intermediate care facilities for the mentally retarded (ICFs/MR), which also includes community residential facilities for the developmentally disabled (CRF/DDs), by reducing the assessment percentage applied to total revenue from six percent to five and one-half percent and applies a fixed rate reduction factor to each provider's rate to account for the corresponding loss of federal match. Effective 30 days after filing with the Publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

405 IAC 1-12-6; 405 IAC 1-12-24

SECTION 1. 405 IAC 1-12-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-6 Active providers; rate review; annual request

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. (a) The rate effective date of the annual rate review established during rebasing years and nonrebasing years shall be the first day of the fourth month following the provider's reporting year-end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) The annual rate review that shall become effective during a rebasing year shall be established using the annual financial report as the basis of the review.

(c) The annual rate review that shall become effective during a nonrebasing year shall be established by applying an inflation adjustment to the previous year's annual or base Medicaid rate **that excludes the rate reduction amount specified in section 24(d) of this rule.** The inflation adjustment prescribed by this subsection shall be applied by using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the previous year's annual or base Medicaid rate period to the midpoint of the current year annual Medicaid rate period prescribed as follows:

Rate Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-6; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2318; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 722; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 2. 405 IAC 1-12-24 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-24 Assessment methodology

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-32-11

Sec. 24. (a) CRF/DD and ICF/MR facilities that are not operated by the state will be assessed an amount ~~not to exceed ten percent (10%) of~~ **that is based on** total annual facility revenue. In determining total annual revenue

when the financial report period is other than three hundred sixty-five (365) days, the total revenue shall be annualized based on the number of days in the reporting period. The assessment percentage applied to total annual revenue shall ~~not exceed the greater of six~~ **be five and one-half** percent ~~(6%) or such~~ **(5.5%) for the period January 1, 2008, through September 30, 2011. Beginning October 1, 2011, the assessment percentage applied to total annual revenue shall be six percent (6%). In no event shall the assessment percentage exceed the** percentage determined to be eligible for federal financial participation under federal law.

(b) The assessment on provider total annual revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. Total annual revenue is defined as revenue from the provider's:

(1) previous reporting period as set out in section 4(a) of this rule; or

(2) previous base rate reporting period set out in section 5(c) of this rule.

Providers will submit data to calculate the amount of provider assessment with their annual and base rate reviews as set out in sections 4(a) and 5(c) of this rule, using forms or in a format prescribed by the office. These forms are subject to audit by the office or its designee.

(c) If federal financial participation to match the assessment becomes unavailable under federal law after the implementation date, the authority to impose the assessment terminates on the date that the federal statutory, regulatory, or interpretive change takes place, and such termination will apply prospectively. In addition, prospective termination of the assessment as described in this subsection will result in the simultaneous termination of the assessment being considered as an allowable cost for rate setting purposes.

(d) Notwithstanding all other provisions of this rule, all annual and base Medicaid rates in effect from the effective date of this rule through September 30, 2011, shall be reduced by the following amounts:

Licensure Type	Rate Reduction Amount
Sheltered living	$1.34
Intensive training	$1.55
Child rearing	$1.89
Developmental training	$1.66
Child rearing with a specialized program	$2.01
Small behavior management residence for children	$2.37
Basic developmental	$2.00
Small extensive medical needs residences for adults	$2.76
Extensive support needs residences for adults	$4.13
Nonstate-operated ICF/MR	$1.38

(e) Notwithstanding all other provisions of this rule, all initial interim Medicaid rates established on or after the effective date of this rule through the end of the first calendar quarter following the effective date of this rule shall be reduced by the following amounts and shall remain reduced for the entire interim rate period:

Licensure Type	Rate Reduction Amount
Sheltered living	$1.34
Intensive training	$1.55
Child rearing	$1.89
Developmental training	$1.66
Child rearing with a specialized program	$2.01
Small behavior management residence for children	$2.37
Basic developmental	$2.00
Small extensive medical needs residences for adults	$2.76
Extensive support needs residences for adults	$4.13
Nonstate-operated ICF/MR	$1.38

(f) For all annual and base rates calculated under this rule effective from the effective date of this rule through September 30, 2011, each provider's assessment costs reported on the cost report and included

in allowable costs will be adjusted to reflect assessment costs at five and one-half percent (5.5%) of total annual facility revenue. Beginning October 1, 2011, each provider's assessment costs reported on the cost report and included in allowable costs will be adjusted to reflect assessment costs at six percent (6%) of total annual facility revenue. In no event shall the allowable cost for the assessment exceed the percentage determined to be eligible for federal financial participation under federal law.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-24; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2329; filed Aug 14, 1998, 4:27 p.m.: 22 IR 67; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:40 a.m.: 25 IR 381; filed Oct 10, 2002, 10:52 a.m.: 26 IR 730; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 3. **All annual and base Medicaid reimbursement rates in effect immediately prior to the effective date of this rule will be recalculated upon the effective date of this rule to implement the rate reductions at section 24(d) of this rule and the adjustment to allowable costs at section 24(f) of this rule. All initial interim Medicaid rates in effect immediately prior to the effective date of this rule will be recalculated upon the effective date of this rule to implement the rate reductions at section 24(e) of this rule.**

Notice of Public Hearing

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